ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

PATIENT NAME: _____ DOB: _____

I, _____, hereby acknowledge that Candlewood Valley Pediatrics has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Practice Privacy Contact
860-355-8190

I also understand that I am entitled to receive updates upon request if Candlewood Valley Pediatrics amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature Relationship to Patient, if signed by someone other than patient.

_____
Date

If the above signature is obtained from someone other than the legally responsible Individual, action taken to obtain legal signature will be:
Given to the above signee to deliver to responsible individual
Sent home via US MAIL
In either situation the parent/legal guardian must sign and return to Candlewood Valley Pediatrics, 120 Park Lane, New Milford CT 06776. Attn: HIPAA Contact

THIS SECTION IS TO BE COMPLETED BY CANDLEWOOD VALLEY PEDIATRICS IF UNABLE TO OBTAIN WRITTEN ACKNOWLDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____ _____
Name and title of employee Date